Wisconsin Guide to Health Insurance for People with Medicare

2004

For more information on health insurance call:
MEDIGAP HELPLINE
1-800-242-1060

This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

For information on how to file insurance complaints call:

INSURANCE COMPLAINT HOTLINE

(608) 266-0103 (Madison)
or
1-800-236-8517 (Statewide)

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's World Wide Web Home Page:
http://oci.wi.gov

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The mission of the Office of

the Commissioner of Insurance . . .

Leading the way in

informing and protecting

the public

and

responding to their

insurance needs.

This guide is not a legal analysis of your rights under any insurance policy or government program. Your insurance policy, program rules, Wisconsin law, federal law and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

The Office of the Commissioner of Insurance (OCI) does not represent that the information is complete, accurate or timely in all instances. All information is subject to change on a regular basis, without notice.

Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently than the hardcopy versions to reflect any necessary changes. Visit OCI's Web site at http://oci.wi.gov.

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Introduction

This booklet briefly describes the Medicare program. It also describes the health insurance available to those on Medicare. A booklet entitled *Medicare Supplement Insurance Approved Polices,* which describes individual and group Medigap insurance policies currently sold in Wisconsin, may be obtained from:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Both booklets are available on our Web site at: http://oci.wi.gov/pub_list.htm. Our Web site also includes information and booklets regarding other types of consumer insurance policies, including long term care insurance, life insurance, and automobile and homeowner's insurance. A list of consumer publications is also included at the back of this booklet.

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers, please contact:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103

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IMPORTANT NOTICE

The state of Wisconsin has received a waiver from the federal A-J standardization regulations on Medicare supplement insurance. This means that policies sold in Wisconsin are somewhat different from those available in other states. This booklet describes only those policies that are available in Wisconsin.

What is Medicare?

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (CMS) for people 65 years of age or older, people of any age with permanent kidney failure, and some disabled individuals under age 65. Although Medicare may pay a large part of your health care expenses, it does not pay for them all. Some services and medical supplies are not fully covered. A handbook titled ***Medicare and You*** is available free from any Social Security office. The handbook provides a detailed explanation of Medicare.

Medicare is divided into two types of coverage, Part A and Part B.

Part A is commonly known as hospitalization insurance. For most people, Part A is premium-free, meaning that you do not have a monthly payment for the coverage. It pays your hospital bills and certain skilled nursing facility expenses. It also provides very limited coverage for skilled nursing care after hospitalization, rehabilitative services, home health care, and hospice care for the terminally ill. It does not pay for personal (custodial) care, such as help with eating, dressing, or moving around. Under Medicare Part A, a period of hospitalization is called a benefit period. A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a nursing facility for 60 consecutive days. If you are re-admitted within that 60 days, you are still in the same benefit period and would not pay another deductible. If you are admitted to a hospital after that benefit period ends, an entirely new benefit period begins and a new deductible must be paid.

Part B is commonly known as medical insurance. It helps pay your doctors' bills and certain other charges, such as surgical care, diagnostic tests and procedures, some hospital outpatient services, laboratory services, physical and occupational therapy, and durable medical equipment. It does not cover prescription drugs, dental care, physicals, or other services not related to treatment of illness or injury.

Everyone pays a monthly premium for Part B if you sign up for the coverage. The premium is automatically taken out of your Social Security check each month. Part B also has a $100 annual deductible and a 20% coinsurance charge for each doctor visit or qualified medical service.

This booklet briefly describes the federal Medicare program and private Medicare supplement insurance as of January 1, 2004. The deductible amounts listed in the charts are for 2004 only.

What Are Specific Limitations Under Medicare?

Medicare was not designed to pay all your health care expenses. It does not cover long-term care expenses. Medicare provides limited coverage for skilled nursing care and for home health care.

Skilled Nursing Care Limitations

Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as defined by Medicare. **Medicare does not pay for personal care such as eating, bathing, dressing, or getting in or out of bed. Most nursing home care is not covered by Medicare!** For more information, contact the Office of the Commissioner of Insurance and ask for the *Guide to Long-Term Care*.

Home Health Limitations

Medicare pays limited benefits for home health care services that are considered "medically necessary" by Medicare. **Medicare does not pay for personal care such as eating, bathing, dressing, or getting in or out of bed. Most home health care services are not covered by Medicare!** For more information, contact the Office of the Commissioner of Insurance and ask for the *Guide to Long-Term Care.*

The Medicare Prescription Drug, Improvement, and Modernization Act

On December 8, 2003, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act. In addition to providing coverage for outpatient prescription drugs, this federal legislation, among other things, will make changes to the traditional Medicare program and to private Medicare supplement insurance plans.

Except for the provision of federally issued prescription drug discount cards, the **legislation does not go into effect until January 1, 2006.** Prescription drug discount cards will become available sometime in the spring of 2004. Check with your county benefit specialist for the effects of this new federal legislation on SeniorCare, the Wisconsin sponsored prescription drug discount program.

Beginning in 2006, anyone eligible for Medicare Part A or enrolled in Part B will be eligible to participate in the new Medicare outpatient prescription drug plan, or Medicare Part D. Participation in the program will be voluntary, but there may be significant penalties for those who do not enroll when they initially become eligible and decide to enroll at a later date.

Additionally, **beginning in 2006**, private Medicare supplement insurance plans will no longer be able to provide outpatient prescription drug coverage. In general, only federally authorized Prescription Drug Plans (PDPs) or Medicare Advantage (currently known as Medicare+Choice) plans will be offering outpatient prescription drug coverage.

For now, the Office of the Commissioner of Insurance (OCI) suggests that people who are in or eligible for Medicare monitor news releases, consumer group publications, and information from state and federal governmental agencies providing information on the new law. OCI will also periodically provide updated information to Medicare-eligible consumers so that they, at the appropriate time, can make informed decisions concerning their health insurance coverage.

What Preventive Care Is Covered Under Medicare?

Medicare covers preventive care services when you have an on-going health care problem that requires that your doctor order these tests. You may be required to pay a portion of the costs for these services. Your Medicare handbook provides more details regarding these costs.

Bone mass measurement – Medicare provides coverage if you are at risk for losing bone mass. You are required to pay the annual Part B deductible before this benefit is payable.

Colorectal cancer screening – Medicare provides coverage for those tests that your doctor determines are appropriate. You are required to pay the annual Part B deductible based on limitations established by Medicare regarding frequency, age requirements, and the specific test involved.

Diabetes monitoring – Medicare provides coverage if you have diabetes whether you use or do not use insulin. Medicare covers lancets, test strips, self-management training, and one blood glucose monitor based on the recommendation of your doctor. You are required to pay the annual Part B deductible before this benefit is payable.

Flu shot – Medicare provides you with coverage for a flu shot once a year. Medicare pays for this benefit whether you have met your Part B deductible or not.

Glaucoma screening – Medicare provides coverage for glaucoma screening once a year if you have diabetes or a family history of glaucoma. You are required to pay the annual Part B deductible before this benefit is payable.

Hepatitis B vaccine – Medicare provides coverage when your doctor recommends vaccination based on an intermediate or high risk. You are required to pay the annual Part B deductible before this benefit is payable.

Mammogram screening – Medicare provides coverage for a mammogram once a year for all women age 40 and over who are covered under Medicare. Medicare pays for this benefit whether you have met your Part B deductible or not.

Medical nutrition therapy – Medicare provides coverage based on your doctor's recommendation if you have diabetes or permanent kidney failure. You are required to pay the annual Part B deductible before this benefit is payable.

Pap smear, pelvic exam, and clinical breast exam – Medicare provides coverage for one exam every 24 months. If you are a high-risk woman, Medicare covers one exam annually. Medicare pays for this benefit whether you have met your Part B deductible or not.

Pneumonia shot - Medicare provides coverage when your doctor recommends a shot that prevents pneumonia. Medicare pays for this benefit whether you have met your Part B deductible or not.

Prostate cancer screening – Medicare provides coverage for a screening once a year for all men age 50 and over who are covered under Medicare. You are required to pay the annual Part B deductible before this benefit is payable; however, PSA tests are not subject to the deductible.

Medicare Hospital Insurance (Part A)

Covered services per calendar year for 2004

Service	Benefit	Medicare Pays	You Pay
Hospitalization Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	All but $876 per benefit period	$876 per benefit period
	Days 61 to 90	All but $219 a day	$219 a day
	Days 91 to 150	All but $438 a day	$438 a day
	Beyond 150 days	Nothing	All costs
Skilled nursing facility care* After a 3-day hospitalization in a facility approved by Medicare within 30 days of discharge	Days 1 to 20	100% of approved amount	Nothing
	Days 21 to 100	All but $109.50 a day	Up to $109.50 a day
	Beyond 100 days	Nothing	All costs
Home health care Medically necessary skilled care	Visits limited to part-time or intermittent nursing care	100% of approved amount for services	Nothing for services
Hospice care Available only to terminally ill	As long as doctor certifies medical need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost-sharing for outpatient drugs and inpatient respite care
Blood	Blood	All but first 3 pints per calendar year	First 3 pints

*Medicare does not pay for most nursing home care. You must pay for custodial care.

Source: Centers for Medicare & Medicaid Services

Medicare Medical Insurance (Part B)

Covered services per calendar year for 2004

Service	Benefit	Medicare Pays	You Pay
Medical expense Physicians' services, physical and speech therapy, durable medical equipment, ambulance, etc.	Reasonable and necessary services	80% of approved amount (after $100 deductible)	$100 deductible plus 20% of balance of approved amount (plus some excess charges above approved amount)
Clinical laboratory services	Blood tests, biopsies, urinalysis, etc.	100% of approved amount	Nothing
Home health care Medically necessary skilled care	Visits limited to part-time or intermittent nursing care	100% of approved amount for services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Some outpatient hospital services and community mental health center partial hospitalization	Unlimited if medically necessary. Emergency room visits, x-rays, stitches for cuts, getting a cast, etc.	A set amount based on prospective payment system (after $100 deductible)	$100 deductible plus a coinsurance or fixed copayment amount for each service based on prospective payment system
Blood	Blood	80% of approved amount (after $100 deductible, starting with the fourth pint)	First 3 pints plus 20% of approved amount (after $100 deductible)

*Medicare does not pay for most nursing home care. You must pay for custodial care.

Source: Centers for Medicare & Medicaid Services

What Does Accepting Assignment Mean?

Sometimes a provider or health care plan accepts "assignment." This means that the doctor or health care plan is paid directly by Medicare and accepts the "Medicare-approved" amount as full payment. A list of doctors in Wisconsin who accept assignment is available from Wisconsin Physicians Service, 1717 W. Broadway, Madison, Wisconsin 53713, or you may check their Web site at http://www.wpsic.com/medicare/bene/find_a_doctor.shtml. The list of doctors may be reviewed at your local Social Security office.

Medicare limits the amount a doctor who does not accept assignment may charge you for Medicare-covered services. Under federal law, your doctor may not charge more than this "**limiting charge**." In 2004, the limit is 115% of the Medicare-approved amount.

The Wisconsin Medical Society and the Coalition of Wisconsin Aging Groups operate "Partnercare," a program through which doctors agree to accept assignment when you are covered under Medicare and your annual household income is under $24,500. For more information on this program, contact your county or tribal aging office or the Wisconsin Medical Society, 330 E. Lakeside St., Madison, WI 53715.

What if a provider does not accept assignment?

A provider who does not accept assignment can charge more than Medicare approves. In this case, you are responsible not only for the usual 20% of the approved charge for the service, but also for 100% of the *excess* charges, which is the portion of the fee that exceeds the approved amount. However, there is a limit to how much more than the approved amount a physician may charge. This is called a limiting charge. Most non-participating physicians may not charge more than 115% of the Medicare-approved amount for a covered service.

What Is Meant by Out-of-Pocket Expenses?

Out-of-pocket expenses occur when you receive a service not covered by Medicare, when you receive a service only partially covered by Medicare, or when you choose a provider whose fees exceed Medicare's approved charges. You will also have to pay out-of-pocket expenses to cover the deductible and copayments. The amount of these expenses you pay out of pocket depends on whether you have insurance that supplements your Medicare coverage.

What are Medicare Supplement Policies?

Medicare was never intended to pay 100% of all medical bills, but instead was created to offset the most pressing medical expenses by providing a basic foundation of benefits. Thus, while it will pay a significant portion of your medical bills, Medicare does not cover all services that you might need. Even those services that are covered are not covered in full. Medicare requires that you pay deductibles, and pays many Part B expenses at 80% of the Medicare approved amount. Insurance companies sell policies that pay some of these expenses if you are enrolled in both Part A and Part B of Medicare. These policies are referred to as "Medicare supplement" or "Medigap" policies and provide a way to fill the coverage gaps left by Medicare. You are automatically eligible for individual Medigap coverage for 6 months starting with the first day you are enrolled in Medicare Part B, regardless of your health history.

Outline of Coverage

The Outline of Coverage contains a chart summarizing the benefits provided by Medicare Parts A and B and the benefits provided by the policy. *The chart also shows the expenses that are not covered by either Medicare or the Medigap policy.* An agent or insurance company must give you an Outline of Coverage when selling you a new policy or replacing one you already own.

Coverage Options Available When You Are Eligible for Medicare

Finding the right coverage at an affordable price may be difficult as no one policy is right for everyone. Coverage options include:

- Group insurance, including
  - Employer group plans
  - Association group plans
- Individual Medicare supplement policies
- Individual managed care Medicare supplement policies, including
  - Medicare select policies
  - Medicare cost policies
- Medicare + Choice plans, including
  - Medicare + Choice HMO plans
  - Medicare + Choice PPP plans
  - Medicare + Choice Private Fee for Service Plans (PFFS)

There are many options available under employer groups, retirement groups, and voluntary association plans. This booklet focuses on the coverage options available under individual Medicare supplement insurance policies, Medicare select insurance policies, Medicare cost insurance policies, and Medicare+Choice insurance policies.

Group Insurance Options

If you are covered under an employer group plan, you may still be eligible for coverage after you reach age 65 either as an active employee or as a retiree. You may also be eligible to purchase coverage through a voluntary association.

Employer Group Plans

If you are currently covered under an employer's group insurance plan, you should determine whether you have the option of continuing coverage or converting to suitable coverage to supplement Medicare before you decide to retire, become eligible for Medicare, or reach age 65. State and federal laws require many employers to offer continued health insurance benefits if your group coverage ends because of divorce, death of a spouse, or termination of employment for reasons other than discharge for misconduct. You should check with your employer for more information.

If either you or your spouse plan to continue working after age 65, you need to take extra care in making insurance decisions. Your group insurance plan may not provide the same coverage you received prior to your 65th birthday.

Federal law determines when Medicare is primary payer and when it is secondary payer. This determination is based on whether you are defined as the employee or dependent under the group insurance policy, and on whether the group insurance policy is offered by an employer with 20 or more employees. You should submit a written request to your insurance company regarding the benefits you will have under the group insurance policy after you or your spouse become eligible for Medicare.

If you continue to work past age 65 and are covered under your employer's group health plan, the employer plan will be your primary insurance over Medicare if your employer has at least 20 employees. If you are 65 and retired, but you are covered under your spouse's employer health plan and your spouse is still employed, that employer plan will be your primary insurance over Medicare if the employer has at least 20 employees.

If you continue to work past age 65 and the group insurance policy is offered by an employer who employs fewer than 20 employees, Medicare is the primary payer. **The group insurance policy may calculate its benefit payment as if you were covered by Medicare regardless of whether you sign up for Medicare Part B benefits**. You will need to consider whether it is advisable for you to enroll in Medicare Part B at 65 or whether you can safely defer Medicare enrollment because of your own or your spouse's active employment status. You should contact your local Social Security office for information on *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You may view this publication on-line at http://www.medicare.gov and click on Publications; enter the CMS publication number 02179.

Your employer may offer a supplement to Medicare through a group retiree plan.

Remember: Employer group coverage is often available regardless of your health and usually does not include any waiting periods for preexisting conditions.

Voluntary Associations Plans

If you do not have adequate group insurance, you may want to apply for a voluntary association plan. Many associations offer group health insurance coverage to their members. However, buying an insurance policy through an association group does not mean that you are getting a low premium rate. Association group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices. Association groups that offer Medicare supplement insurance must comply with the same rules that apply to other Medicare supplement policies.

Individual Policy Options

Many insurance companies offer to individuals eligible for Medicare individual policies that supplement the benefits available under Medicare. These policies are referred to as Medicare supplement or Medigap policies.

The federal government has expanded the options available to include managed care plans that require that you see only network providers to receive optimum benefits, and plans whereby the insurance company agrees to provide all Medicare benefits.

Medicare Supplement Policies

Individual Medicare supplement policies are designed to supplement the benefits available under the original Medicare program. Medicare supplement policies pay the 20% of Medicare-approved charges that Medicare does not pay. These Medicare supplement policies do not restrict your ability to receive services from the doctor of your choice. However, these policies may require that you submit your claim to the insurance company for payment.

Individual Medicare supplement policies include a basic core of benefits. In addition to the basic benefits, Medicare supplement insurers offer specified optional benefits. Each of the options that an insurance company offers must be priced and sold separately from the basic policy.

Some insurance companies offer high deductible plans. Benefits are provided after you have paid a calendar year deductible that changes yearly. For the year 2004, the deductible is $1,690. This deductible consists of expenses that would ordinarily be paid by the policy. The minimum required benefits and the optional benefits are described on page 17.

Medicare Select Policies

Medicare select policies supplement the benefits available under the Medicare program and are offered by insurance companies and health maintenance organizations (HMOs). Medicare select policies are similar to standard Medicare supplement insurance. However, Medicare select policies pay supplemental benefits only if covered services are obtained through plan providers selected by the insurance company or HMO. Each insurance company that offers a Medicare select policy contracts with its own network of plan providers to provide services.

If you buy a Medicare select policy, each time you receive covered services from a plan provider, Medicare pays its share of the approved charges and the insurance company pays the full supplemental benefits provided for in the policy. Medicare select insurers must pay supplemental benefits for emergency health care furnished by providers outside the plan provider network.

In general, Medicare select policies deny payment or pay less than the full benefit if you go outside the network for nonemergency services. However, Medicare still pays its share of approved charges if the services you receive outside the network are services covered by Medicare.

All Medicare select policies include a basic core of benefits. Medicare select insurers may offer only one separately priced option, which is the Outpatient Prescription Drug Rider. The minimum required benefits and the optional rider are described on page 18.

Medicare Cost Policies

Medicare cost policies are offered by certain HMOs who have entered into a special arrangement with the federal Centers for Medicare & Medicaid (CMS). The HMOs agree to provide Medicare benefits. The HMOs may provide additional benefits at additional cost. Medicare cost insurance will only pay full supplemental benefits if covered services are obtained through HMO plan providers. You must live in the plan service area to apply for Medicare cost insurance. The HMO plan providers are selected by the HMO.

Medicare cost policies do not require that you be "locked in" to the HMO plan providers for your Medicare benefits. Medicare will still pay its share of approved charges if the services you receive outside the network are services covered by Medicare. However, if you go to a health care provider who does not belong to your HMO without a referral from your HMO physician, you will pay for all Medicare deductibles and copayments. The HMO will not provide supplemental benefits.

Remember: If you buy a policy from an HMO, you do not have to file claims. Except for out-of-area claims, the HMO takes care of all your paperwork. You also are not responsible for the charges in excess of Medicare's approved charge.

Medicare+Choice Policies

Medicare+Choice policies are offered by certain HMOs or insurance companies that have entered into special arrangements with the federal Centers for Medicare & Medicaid Services (CMS). Under these arrangements the federal government pays the HMO or insurance company a set amount for each Medicare enrollee. The HMO or insurance company agrees to provide all Medicare benefits. The HMO or insurance company may provide some additional benefits, which may be at an additional cost.

Your Medicare+Choice policy can terminate at the end of the contract year if either the plan or CMS decides to terminate their agreement.

Medicare+Choice policies are not regulated by the state of Wisconsin Office of the Commissioner of Insurance. Therefore, these plans are **NOT** required to cover Wisconsin mandated benefits, nor are the plans guaranteed renewable for life like other Medicare supplement policies.

You can obtain more information by requesting a copy of OCI's brochure *Medicare+Choice Questions and Answers*. You may also call CMS customer service at (312) 353-7180 for information.

Medicare+Choice Health Maintenance Organization Plans

If you enroll in a Medicare+Choice policy through a health maintenance organization (HMO) that has contracted with CMS, you are "locked in." This means that, except for emergency or urgent care situations away from home, you must receive all services, **including Medicare services,** from HMO contracted providers. If you go to a health care provider who does not have a contract with your HMO without a referral from your physician, you will be responsible for the entire cost of the services you receive, **including Medicare costs.** To be eligible for a Medicare+Choice policy through an HMO, you must live in the HMO's service area.

Medicare+Choice Preferred Provider Plan Plans

You may also enroll in a Medicare+Choice policy through an insurance company with a preferred provider plan (PPP) that has entered into a contract with CMS. Medicare+Choice PPP plans are similar to HMO plans in that **if you enroll in a PPP plan, you are "locked in."** In order to receive full coverage under the PPP option, you must receive all services, except for emergency or urgent care situations away from home, from plan providers. However, you may receive services from providers outside the plan at an additional cost.

Medicare+Choice Private Fee-For-Service Plans

Medicare+Choice private fee-for-service (PFFS) plans differ from HMO and PPP plans because they allow you to go to any doctor, hospital, or health care provider that agrees to accept the PFFS plan's terms of payment. PFFS plans do not have contracts with doctors, hospitals, or health care providers. You do not have to obtain a referral from the plan to go to a doctor, hospital, or specialist of your choice. **However, it is your responsibility to verify that the provider is willing to accept the PFFS plan's payment terms.**

Basic Benefits Included in Medicare Supplement Policies

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance.
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first three pints of blood each year.

Medigap Benefits	Basic Plan
Basic Benefits	√
Medicare Part A: Skilled Nursing Facility Coinsurance	√
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Medicare Part B: Coinsurance	√
Outpatient Mental Health	√
Catastrophic Prescription Drugs (after a deductible of $6,250, pays 80%)	√

Optional Riders

- Medicare Part A Deductible
- Additional Home Health Care (365 visits including those paid by Medicare)
- Medicare Part B Deductible
- Medicare Part B Excess Charges
- Foreign Travel
- Prescription Drug Rider

Insurance companies are allowed to offer additional riders to a Medicare supplement policy.

Source: Centers for Medicare & Medicaid Services

Basic Benefits Included in Medicare Select Policies

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance.
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first three pints of blood each year.

Medigap Benefits	Basic Plan
Basic Benefits	√
Medicare Part A Deductible	√
Medicare Part A: Skilled Nursing Facility Coinsurance	√
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	365 visits including those paid by Medicare
Medicare Part B Deductible	√
Medicare Part B: Coinsurance	√
Outpatient Mental Health	√
Foreign Travel	√
Catastrophic Prescription Drugs (after a deductible of $6,250, pays 80%)	√

Optional Riders
Insurance companies are allowed to offer additional riders to a Medicare select policy. • Prescription Drug Rider

Source: Centers for Medicare & Medicaid Services

What Additional Benefits are Mandated?

Wisconsin insurance law requires that individual Medicare supplement policies, Medicare select policies, and Medicare cost policies contain the following "mandated" benefits. These benefits are available even when Medicare does not cover the claim.

Skilled Nursing Facilities—Medicare supplement and Medicare select policies cover 30 days of skilled nursing care in a skilled nursing facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care. No prior hospitalization may be required. The facility must be a licensed skilled care nursing facility.

Home Health Care—Medicare supplement and Medicare select policies cover up to 40 home care visits per year in addition to those provided by Medicare, **if you qualify.** Your physician must certify that you would need to be in the hospital or a skilled nursing home if the home care was not available to you. Home nursing and medically necessary home health aide services are covered on a part-time or intermittent basis, along with physical, respiratory, occupational, or speech therapy.

Insurers are required to offer coverage for 365 home health care visits in a policy year. Insurers may charge an additional premium for the additional coverage. Medicare provides coverage for all medically necessary home health visits. However, "medically necessary" is defined quite narrowly, and you must meet certain other criteria.

Kidney Disease—Medicare supplement and Medicare select policies cover inpatient and outpatient expense for dialysis, transplantation, or donor-related services of kidney disease up to $30,000 in any calendar year. Policies are not required to duplicate Medicare payments for kidney disease treatment.

Diabetes Treatment—Medicare supplement and Medicare select policies cover the usual and customary expenses incurred for the installation and use of an insulin infusion pump or other equipment or supplies, including insulin, and for prescription drugs for the treatment of diabetes. Self-management services are also considered a covered expense. This benefit is available even if Medicare does not cover the claim. However, prescription drug expenses are subject to the $6,250 deductible for drug charges. This deductible does not apply to insulin.

Chiropractic Care—Medigap policies cover the usual and customary expense for services provided by a chiropractor. This benefit is available even if Medicare does not cover the claim.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care—
Medicare supplement and Medicare select policies cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care for an individual with a chronic disability or an individual with a medical condition that requires hospitalization or general anesthesia for dental care.

Breast Reconstruction—Medicare supplement and Medicare select policies cover breast reconstruction of the affected tissue incident to a mastectomy.

Catastrophic Prescription Drugs—Medicare supplement and Medicare select policies provide coverage for at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year.

Medicare+Choice insurance plans are not required to cover Wisconsin's mandated benefits. The limitation and exclusion section of the summary of benefits included in the Medicare+Choice policy lists any mandated benefits not covered by the plan.

Basic Facts About Medicare Supplement Policies

Open Enrollment

Medicare supplement and Medicare select insurance companies must make coverage available to you, regardless of your age, for 6 months beginning with the date you enroll in Medicare Part B. This 6-month period is often called the **open-enrollment period**. Insurance companies may not deny or condition the issuance of a policy on your health status, claims experience, receipt of health care, or medical condition. The policy may still have waiting periods before preexisting health conditions are covered. In addition, if you are under age 65 and eligible for Medicare due to disability or end stage renal disease, you are entitled to a 6-month open enrollment period upon reaching age 65.

Medicare cost and Medicare+Choice insurance plans accept applicants who live in the plan service area, have Medicare Part A and Part B, and do not have permanent kidney failure. Until 2005, most Medicare+Choice plans will allow you a monthly right to change plans.

Guarantee Issue

In addition to the open enrollment period, you have the right to enroll in a Medicare supplement or Medicare select policy regardless of your health status if your other health coverage terminates. The insurance company must offer you one of these Medigap plans if:

- Your Medicare+Choice or Medicare cost plan stops participating in Medicare or providing care in your service area; or
- You move outside the plan's service area; or
- You leave the health plan because it failed to meet its contract obligations to you; or
- Your employer group health plan ends some or all of your coverage; or
- Your Medicare supplement insurance company ends your Medigap or Medicare select policy and you're not at fault (for example, the company goes bankrupt); or
- You drop your Medigap policy to join a Medicare+Choice plan, a Medicare cost plan, or buy a Medicare select policy for the first time, and then leave the plan or policy within one year after joining, but you must return to the policy under which you were originally covered, if available; or
- You join a Medicare+Choice plan, or a Medicare cost plan and within one year of joining, you decide to leave the health plan.

As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage (except for the prescription drug rider) or place conditions on the policy (such as a waiting period),

- Must cover you for all preexisting conditions, and

- Cannot charge you more for a policy because of past or present health problems.

The insurance company terminating coverage must provide a notification that explains individual rights to guarantee issue of Medigap plans. You must submit a copy of this notice or other evidence of termination with the application for the new policy.

30-day Free Look

All Medicare supplement and Medicare select insurance policies sold in Wisconsin have a 30-day free look period. If you are dissatisfied with a policy, you may return it to the insurance company within 30 days and get a full refund if no claims have been made. You should use the time to make sure the policy offers the benefits you expected. Check the application for accuracy and check the policy for any limitations, exclusions, or waiting periods. Medicare+Choice contracts also permit disenrollment.

Renewability

Policies that are guaranteed renewable offer added protection. Be sure to ask the agent or company about the renewability of the policy. All Medicare supplement and Medicare select policies sold today must be guaranteed renewable for life. This means that you can keep the policy as long as you pay the premium. **It does not mean that the insurance company cannot raise the premium.**

Medicare+Choice plans are not guaranteed renewable. Medicare+Choice insurance plans are a special arrangement between federal CMS and certain HMOs or insurance companies. Either CMS, HMOs, or insurance companies may choose to terminate plans at the end of any calendar year.

Midterm Cancellation

All Medicare supplement policies include the right to a pro rata refund of premium if you want to cancel a policy before the end of a term. All you need to do is to send the Medicare supplement policy to the insurance company with a letter requesting cancellation. The right to midterm cancellation does not apply to Medicare cost or Medicare+Choice contracts.

Waiting Periods, Limitations, and Exclusions

Many Medicare supplement insurance policies have waiting periods before coverage begins. If your policy excludes coverage for preexisting conditions for a limited time, it must provide this information on the first page of the policy. The waiting period for preexisting conditions may not be longer than **6 months**, and only conditions treated during the 6 months before the effective date of the policy may be excluded.

Insurance companies are required to waive any waiting periods for preexisting conditions if you buy a Medicare supplement policy during the open enrollment period and have been continuously covered with creditable coverage for at least 6 months prior to applying for the Medicare supplement policy. Insurance companies are also required to waive any waiting periods for preexisting conditions when one Medicare supplement policy is replaced with another.

Remember: For the first 6 months after you first enroll in Part B of Medicare, insurance companies must accept you regardless of your health. Some companies have continuous open enrollments. However, the policies may include waiting periods before coverage begins.

Common Exclusions

No insurance policy will cover everything that is not covered by Medicare. Medicare excludes certain types of medical expenses. *So do many Medicare supplement, Medicare select, Medicare cost, and Medicare +Choice policies.*

Some services that are frequently excluded under these policies are: *custodial care in nursing homes, private duty nursing, routine check-ups, eye glasses, hearing aids, dental work, cosmetic surgery, and prescription drugs up to $6,250 each year.* Some policies may include benefits for prescription drugs.

Medigap policies include two other exclusions that are frequently misunderstood:

1. Medicare pays only for charges that are considered reasonable and services that are considered necessary. Medicare's determination of a reasonable or "approved" charge may be much less than the actual charge for a covered service. For example:

Doctor's bill	$115
Medicare-approved	100
Medicare pays	80

   In the example above, Medicare pays 80% of the approved charge ($80). Medicare supplement policies pay only the 20% difference between what Medicare approves and what Medicare pays ($20). If your doctor accepts assignment, you will not be charged the difference between what Medicare approves and the doctor's bill. Otherwise, you will be responsible for that portion of the bill. If you have the Medicare Part B Excess Charges Rider, the policy will pay the difference between what Medicare approves and the doctor's charge.

   Medicare select and Medicare cost policies cover the entire charge for covered services if you use doctors and hospitals connected to the plan. Medicare+Choice policies may charge a copayment for doctor office and emergency room visits.

2. Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare **if your doctor certifies that it is necessary and you meet certain other criteria.** There are **no** benefits for custodial care. In general, Medicare supplement, Medicare select, Medicare cost, and Medicare+Choice policies cover only skilled care, and do not cover custodial or intermediate care. Skilled nursing care is quite narrowly defined.

Your Grievance and Appeal Rights

Grievance Procedure

If you have a complaint or question, you may wish to first contact your insurance company. Many complaints can be resolved quickly and require no further action. However, you do not have to file a complaint with your insurance company before you file a complaint with the appropriate state agency.

All insurance companies are required to have an internal grievance procedure. If you are not satisfied with the service you receive, your insurance company must provide you with complete and understandable information about how to use the grievance procedure. You have the right to appear in person before the grievance committee and present additional information.

Insurance companies are required to have a separate expedited grievance procedure for situations where your medical condition might require immediate medical attention. The procedure requires insurance companies to resolve an expedited grievance within 72 hours after receiving the grievance.

Medicare supplement insurance companies are required to file a report with OCI listing the number of grievances they had in the previous year.

Benefit Appeal

If you are not satisfied with the denial of a benefit by your Medicare supplement insurance company, you may appeal the decision. The insurance company must offer you the opportunity to submit a written request that the insurance company review the denial of benefits. Your policy or group insurance certificate and Outline of Coverage describe the benefit appeal procedure. If the insurance company denies any benefit under your Medigap policy, the insurance company must, at the time of denial, provide you with a written description of its appeal process.

Independent Review

If you are not satisfied with the outcome of a grievance, and the grievance involves a dispute regarding medical necessity or experimental treatment, you or your authorized representative may request that an independent review organization (IRO) review your insurance company's decision. The independent review process provides you with an opportunity to have medical professionals who have no connection to the insurance company review the dispute. You can choose an IRO from a list of review organizations certified by OCI. The IRO assigns the dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether the treatment should be covered by the insurance company.

Your insurance company will provide you with information on the availability of this process whenever it makes a determination that is eligible for the independent review process.

Consumer Buying Tips

Cost of Policies

When buying a Medicare supplement policy, you should find out exactly what the premium will be. A few insurance companies charge everyone the same amount. Most companies charge different premiums based on your age at the time of application. Several companies also use other factors, such as different rates for men and women or different rates in different parts of the state.

You should also find out what happens to your premium as you get older. The premium for your policy will increase every year primarily due to inflation in medical costs and the increase in Medicare deductibles and copayments. The amount your premium increases may also depend on the way in which the company reflects the aging of its policyholders in the rates charged. Be sure to ask the agent for any company you are considering to explain the approach the company uses. In general, insurance companies use one of the methods described below:

Attained Age. In addition to medical inflation and increased Medicare deductibles and copayments, your premium will also increase as you age. This is due to the fact that you tend to use more medical services as you age.

Issue Age. Your premium will increase due to medical inflation and increased Medicare deductibles and copayments. It will not increase due to your age. Your initial premium will be somewhat higher than under the Attained Age approach because a portion of the initial premium is used to prefund the increased claims cost in later years. As a result, the premium for later years should be somewhat less than it would be under an Attained Age approach.

No Age Rating. Your premium is the same as for all customers who buy this policy, regardless of age.

Under Age 65. Your premium is calculated for individuals who, due to a disability, are eligible to enroll in Medicare under age 65.

Policy Delivery and Refunds

Policy delivery or refunds on policies should be made promptly by insurance companies. If you do not receive your policy within a month, or if there is a delay in receiving a refund, call or write the insurance company.

If you buy from an agent, find a good local insurance agent who can help you buy the right policy and will also assist you with making claims.

Policy Storage

Keep the policy in a safe place. It is a good idea to choose someone ahead of time who can take over your affairs in case of a serious illness. This person should know where your records are kept.

Duplicate Coverage

Buy only one policy. Buying one comprehensive health insurance policy is much better than buying several limited policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

Health History

Do not be misled that your medical history on an application is not important. Omitting specific medical information on your application can be very costly. If your application for individual Medigap insurance includes questions about your health, be sure that you answer *all* medical questions completely and accurately. If an agent helps you fill out the application, *do not* sign the application until you read it. If you omit medical information and the insurance company finds out about it later, the company may deny your claim and/or terminate your policy.

Since the application is part of the insurance contract, you will receive a copy with the policy. Make sure that the application has not been changed and that all the medical information in the application is accurate.

Payment

Make checks payable only to the insurance company—do not pay cash or make a check out to the agent. Be sure you have the agent's name, address, and Wisconsin agent's license number, and the name and address of the company from which you are buying the policy.

What If I Can't Afford a Medicare Supplement Policy?

You may find that you can no longer afford to pay insurance premiums and are eligible for the Medicaid program. The Medicaid program provides health care coverage for individuals who meet the program's definition of low income. If you do not qualify for the Medicaid program, you may be eligible for several other options based on your income.

Medicaid Program

If you are eligible for Medicaid, you do not need to buy private health insurance. Medicaid pays almost all of the health care costs if you are eligible for the program. For more information, contact your county or tribal aging office. If you bought a Medicare supplement policy after November 5, 1991, and then become eligible for Medicaid, the law permits you to suspend your coverage for 24 months while you are enrolled in the Medicaid program.

If you lose your eligibility for Medicaid within 24 months, the law permits you to reinstate your Medicare supplement insurance. If you are on Medicaid longer than 24 months, your policy will terminate.

Qualified Medicare Beneficiary and Specified Low-Income Beneficiary Programs

If you are a low-income Medicare beneficiary but don't qualify for the standard Medicaid program, you may be eligible for either the Qualified Medicare Beneficiary program (QMB) or the Specified Low-Income Medicare Beneficiary program (SLMB). While these programs do not necessarily eliminate your need for private insurance to supplement your Medicare benefits, they could save you hundreds of dollars each year in health care costs if you qualify for assistance.

The QMB program pays Medicare's premiums, deductibles, and coinsurance amounts if you are entitled to Medicare Part A, and your annual income is at or below the national poverty level, and your savings and other resources are very limited. The QMB program, therefore, functions like a Medigap policy and more because it also pays your Part B premium.

The SLMB program pays your Medicare Part B premium if you are entitled to Medicare Part A and your income does not exceed the national poverty level by more than 20%. If you qualify for assistance under the SLMB program, you will be responsible for Medicare's deductibles, coinsurance, and other related charges.

In addition, you may be eligible for a Medicaid program that requires states to pay Medicare Part B premium assistance for low-income Medicare beneficiaries. Contact the state or local Medicaid or social services office or your benefit specialist to get more detailed eligibility information or to apply.

Limited Policies

The limited policies listed below should not be bought as substitutes for a comprehensive Medigap policy.

Long-Term Care Coverage - These policies cover long-term nursing home and/or home health care.

You may obtain a copy of the booklets *Guide to Long-Term Care* and *Long-Term Care Insurance Approved Policies in Wisconsin* from the Office of the Commissioner of Insurance.

Hospital Confinement Indemnity Insurance - These policies pay a fixed amount per day for a specific number of days during the time you are hospitalized. These policies are not related to Medicare and may not be necessary if you have a Medicare supplement, Medicare select, Medicare cost, or Medicare+Choice policy. You should review these policies carefully to determine the number of days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage - These policies provide benefits for a single disease or group of specified diseases, such as cancer, and are not Medicare supplement or Medigap policies. *These policies should not be bought as alternatives to more comprehensive coverage. A Shopper's Guide to Cancer Insurance* prepared by the National Association of Insurance Commissioners is available from the Office of the Commissioner of Insurance.

ATTENTION

Federal law prohibits the sale of a health insurance policy that pays benefits in addition to Medicare unless it will pay benefits without regard to other health coverage and it includes a disclosure statement on or together with the application.

SeniorCare Prescription Drug Assistance Program

Wisconsin residents who are 65 years of age or older and who meet certain requirements are eligible for a prescription drug assistance program. The SeniorCare program is designed to make your prescription drugs more affordable and to make it easier for you to obtain the medicine you need.

The program's eligibility requirements include that you must be a Wisconsin resident 65 years of age or older and pay a $20 annual enrollment fee per person. The program considers only your income for eligibility. Assets, such as bank accounts, insurance policies, home, and property, are not counted as income under this program.

Under SeniorCare, you will need to pay out-of-pocket expenses depending on your annual income. There are different expense requirements and benefits based on your income and your spouse's income, if your spouse lives with you.

You should contact your county or tribal aging office for more information regarding this program and eligibility requirements, or call the SeniorCare Customer Service Hotline at 1-800-657-2038.

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a free counseling service for Medicare beneficiaries that provides information regarding Medicare and Medigap insurance policies.

SHIP's Medigap Helpline (1-800-242-1060) can help you with questions about health insurance, primarily Medicare supplements, long-term care insurance, and other health care plans available to Medicare beneficiaries. The Medigap Helpline is provided by the state of Wisconsin Board on Aging and Long Term Care at no cost to you. There is no connection with any insurance company.

Filing a Claim

It is important to file claims properly. The following list will help:

- Keep an accurate record of all your health care expenses. Store this information with your Medigap insurance or other health insurance policies.

- Whenever you receive treatment, present your Medicare card and any other insurance card you have.

- File all claims promptly. With each claim payment from Medicare, you will receive an "Explanation of Benefits" (EOB). If the insurance company requests a copy of the Medicare EOB, make a copy of the EOB and record the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.

- You do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare provider must submit claims to Medicare for you.

- If you enroll in a health maintenance organization (HMO), you will not have to file claims for services covered by HMO providers. All claims for covered services will be handled by the HMO.

- Some Medicare supplement insurance companies have an automatic claims filing program. This means that the insurance company receives a copy of the claim as soon as it is processed by Medicare. There may be a charge for this service.

- For more information on filing claims, you may want to contact the benefit specialist at your county or tribal aging office.

NOTE

Under Wisconsin law, all Medicare supplement and Medicare select insurance policies must include an appeal procedure for claim denials. This procedure will be explained in your policy and Outline of Coverage.

Glossary of Terms

Actual charge: The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Appeal: An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. This complaint is made to your Medicare health plan or to Medicare. There is usually a special process you must use to make your complaint.

Approved amount or charge: Also called the allowable, eligible, or accepted charge, this is the maximum fee set by Medicare that it will approve for a particular service or procedure, of which Medicare will reimburse 80%.

Assignment: This means that a doctor agrees to accept Medicare's fee as full payment. Accepting assignment means that the doctor agrees to bill no more than the approved charge for a service. In other words, a doctor will not charge more than Medicare will approve.

Attained age: This means that as you age, your premiums will change to meet your age range and your premiums will become higher.

Beneficiary: The name for a person who has health insurance through the Medicare program.

Benefit period: A designated period of time during and after a hospitalization for which Medicare Part A will pay benefits.

Carrier: A private company that has a contract with Medicare to process your Medicare Part B bills.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program.

Coinsurance: The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. If you have supplemental coverage, this is the balance of a covered health expense that you are required to pay after insurance has covered the rest.

Coordination of benefits: A process that determines the plan or insurance policy that pays first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first.

Copayment: The amount you pay for each medical service. A copayment is usually a set amount you pay for a service.

Custodial care: Personal care, such as help with activities of daily living, like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. Medicare does not pay for custodial care.

Deductible: The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Durable Medical Equipment (DME): Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Excess charge: The difference between a doctor's or other health care provider's actual charge and the Medicare-approved payment amount.

Enrollment period: The 6-month period after you turn 65, during which you can enroll in any Medicare supplement insurance plan or policy if you have enrolled in Medicare Part B. During this period, you cannot be denied based on any preexisting medical condition.

Explanation of Medicare benefits (EOMB): A notice that is sent to you after the doctor files a claim for Part B services that explains what the provider billed, the Medicare-approved amount, how much Medicare paid, and the amount you must pay.

Free look period: The 30-day period of time when you can review a Medicare supplement policy. If you change your mind about keeping the policy during this 30-day period, you can cancel the policy and get your money back.

Grievance: Your right under Wisconsin insurance law to file a written complaint regarding any dissatisfaction with your policy or plan regarding mandated benefits. Medicare also provides you the right to file a grievance if you have a problem calling the plan, staff behavior, or operating hours. Medicare has a separate appeal process for complaints about a treatment decision or a service that is not covered.

Guaranteed issue rights: Rights you have in certain situations when insurance companies are required to accept your application for a Medicare supplement policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all preexisting conditions, and cannot charge you more for a policy because of past or present health problems.

Guaranteed renewable: A right you have to automatically renew or continue your Medicare supplement policy, unless you commit fraud or do not pay your premiums.

Issue age: Premiums are set at the age you are when you buy the policy and will not increase because you get older. Premiums may increase for other reasons.

Limiting charge: The maximum a physician who does not accept assignment may legally charge for a Medicare-covered service.

Managed care: A health plan that has an established network of providers that you must use.

Medically necessary: Services or supplies that are needed for the diagnosis or treatment of your medical condition; are provided for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of you or your doctor.

Network: A group of doctors, hospitals, pharmacies, and other health care experts that have entered into an agreement with a health plan to take care of its members.

Nonparticipating physician: A doctor or supplier who does not accept assignment on all Medicare claims. A doctor or supplier who does not have a network agreement with a managed care plan.

Open enrollment period: A one-time only 6-month period when you can buy any Medicare supplement policy you want that is sold in Wisconsin. It starts when you sign up for Medicare Part B and you are age 65 or older. You cannot be denied coverage or charged more due to present or past health problems during this time period.

Out-of-pocket costs: Medical costs that you must pay on your own because they are not covered by Medicare or other insurance.

Preexisting condition: A medical condition diagnosed or treated up to six months prior to the purchase of an insurance policy. Medicare supplement policies may impose up to a 180-day waiting period before coverage for that condition begins.

Primary payer: An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Referral: An approval from your primary care doctor and health plan for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Secondary payer: An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

Service area: The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

State Health Insurance Assistance Program (SHIP): A state program that gets money from the federal government to give free health insurance counseling and assistance to people with Medicare.

Usual and customary charge: The fee most commonly charged by providers for a particular service, procedure, or treatment, for that specialty, in that geographic area.

Waiting period: The time between when you sign up with a Medicare supplement insurance company or Medicare health plan and when the coverage starts.

What if I Have Additional Questions or Complaints?

If you have questions or complaints about:

Health Insurance

- **Board on Aging and Long Term Care (BOALTC)** (http://longtermcare.state.wi.us/home/)
  800-242-1060 - Medigap Helpline

  This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long-Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

  Address
  Board on Aging and Long Term Care
  1402 Pankratz Street, Suite111
  Madison, WI 53704-4001

  1-800-242-1060 - Medigap Helpline
  (608) 246-7001 Fax

- **Office of the Commissioner of Insurance (OCI)** (http://oci.wi.gov)
  1-800-236-8517 (statewide)
  (608) 266-0103 (Madison)
  711 TDD (ask for 608-266-3586)

  OCI publishes several consumer guides to assist seniors in their shopping for insurance. The publications should be used only as a guide. These guides are not legal documents and do not represent your rights under any insurance policy or government program. Your policy, contract, or federal or state laws establish your rights. Consult an attorney for legal guidance about your specific rights; legal assistance may also be available through your county or tribal aging office.

  If you are having a problem with your insurance, you should first check with your agent or with the insurance company that sold you the policy. If you do not get satisfactory answers, you may file a complaint with OCI.

  Mailing Address
  P.O. Box 7873
  Madison, WI 53703-7873

  Street Address
  125 South Webster Street
  Madison, WI 53702
  1-800-236-8517 (statewide) or (608) 266-0103 (Madison)
  711 TDD (ask for 608-266-3586)

Medicare

- **Centers for Medicare & Medicaid Services (CMS)** (http://www.cms.gov/)
  1-877-267-2323 (toll-free)
  1-866-226-1819 TTY (toll-free)

  The Centers for Medicare & Medicaid Services is the federal agency that manages the Medicare and Medicaid programs.

  Address
  7500 Security Boulevard
  Baltimore MD 21244-1850

  Billing Medicare - Wisconsin Information

  Medicare Carrier
  Part B bills and services

  Wisconsin Physician Services
  1-800-944-0051 (toll-free)
  1-800-828-2837 TTY (toll-free)

  Phone Number
  1-800-531-9695 (toll-free)
  1-800-722-8140 TTY (toll-free)

  Fiscal Intermediary
  Part A bills and services, hospital care, skilled nursing care, and fraud

  Blue Cross Blue Shield of Wisconsin
  (d.b.a. United Government Services, LLC)
  1-800-531-9695 (toll-free)
  1-866-879-0234 TTY (toll-free)

Partnercare

The Wisconsin Medical Society and the Coalition of Wisconsin Aging Groups operate a program through which doctors agree to accept assignment for those whose annual household income is under $24,500. For more information on this program, contact your county or tribal aging office (http://www.dhfs.state.wi.us/aging/contacts/COAGOF.HTM).

SeniorCare (http://www.dhfs.state.wi.us/seniorcare/index.htm)

SeniorCare is Wisconsin's prescription drug assistance program for Wisconsin residents who are 65 years of age or older and who meet eligibility requirements.

1-800-657-2038 SeniorCare Customer Service Hotline
(TTY and translations services are available.)

If you think you are eligible, contact your county or tribal aging office for more information (http://www.dhfs.state.wi.us/seniorCare/HowWhere.htm).

Medicare Supplement Policy Checklist

Use this chart to compare cost and benefits of policies you are considering.

Name of Company	Name of Company
Name of Agent	Name of Agent
Cost of Policy 1:	Cost of Policy 2:

	Basic Policy	Policy 1 Optional Benefits		Policy 2 Optional Benefits	
		Coverage	Cost	Coverage	Cost
PART A **Hospital** Initial Deductible ($876)	NC				
61st to 90th Day ($219 a day)	C				
91st to 150th Day ($438 a day)	C				
After 150th Day (100%)	C				
Skilled Nursing Facility (SNF)* 21st to 100th Day ($109.50 a day)	C				
After 100th Day	NC				
Home Health Care	40 Visits				
Blood (1st three pints)	C				
Part B **Medical Expenses** Initial Deductible ($100)	NC				
Medicare-Approved Expenses (20%)	C				
Beyond Medicare-Approved Expenses	NC				
Outpatient Prescription Drugs below $6,250 in charges	NC				
Foreign Travel	NC				
Other Benefits Diabetic Supplies and Equipment	C				
Chiropractic Care	C				
Preventive Care - Physical Exam	NC				

C = Covered NC = Not Covered

* Basic policy also covers 30 days in a skilled nursing facility even if stay is not covered by Medicare.